Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL SAN ANTONIO
4243 E SOUTHCROSS BLVD
SAN ANTONIO TX 78222-3727

Respondent Name
CASTLEPOINT NATIONAL INSURANCE

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-10-4525-01

MFDR Date Received
June 25, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital no choice but to seek medical fee dispute resolution."

Amount in Dispute: $50,401.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The state of Texas adopted the new MS-DRG classification system for Workers' Compensation services effective 03/01/08. This includes provider-specific rates as well as the new MS-DRG rates. Further, the Texas stop loss is no longer effective as of 3/1/08. Based on this information it is the Carrier's position that no additional consideration is due in this matter."

Response Submitted by: SUA Insurance Company, PO Box 154110, Irving TX 75015

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2009	Outpatient Hospital Services	$50,401.98	$5,074.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
     - $11.55
     - $14.19
     - $252.12
     - $293.67
     - $36.78
     - $4.28
     - $492.80
     - $5.33
     - $5.88
     - $53.13
     - $583.06
     - $892.80
   - 595-003 – REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT.
   - 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDERS REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
   - 930-196 – MEETING STATE REQUIREMENTS TO ELECTRONICALLY EXCHANGE MEDICAL BILLING AND REIMBURSEMENT DATA. SUA HAS CONTRACTED WITH COVENTRY WCSERVICES AS THEIR PROCESSING AGENT. CWCS'S EBILLING PARTNER IS JOPARI SOLUTIONS. FOR INFORMATION CALL 1-866-269-0554.
   - 855-002 – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES.
     - $11.55
     - $14.19
     - $252.12
     - $293.67
     - $36.78
     - $4.28
     - $492.80
     - $5.33
     - $5.88
     - $53.13
     - $583.06
     - $892.80

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the

separately reimbursed implantable items are $8,556.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99070 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Per Medicare policy, payment for these supply items is always bundled into payment for other services performed on the same date. Separate payment is not recommended.

   - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.

   - Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.24. 125% of this amount is $11.55. The recommended payment is $11.55.

   - Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of $1,739.41. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,039.85. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of $15,925.00 yields a cost of $3,788.56. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,039.85 divided by the sum of all APC payments is 86.34%. The sum of all packaged costs is $7,328.51. The allocated portion of packaged costs is $6,327.74. This amount added to the service cost yields a total cost of $10,116.30. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,796.56. 50% of this amount is $2,398.28. The total APC payment for this service, including outliers, is $5,438.13. This amount multiplied by 130% yields a MAR of $7,069.57.

   - Procedure code 23655 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0045, which, per OPPS Addendum A, has a payment rate of $1,028.36. This amount multiplied by 60% yields an unadjusted labor-related amount of $617.02. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of $550.20. The non-labor related portion is 40% of the APC rate or $411.34. The sum of the labor and non-labor related amounts is $961.54. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers and multiple procedure discount, is $480.77. This amount multiplied by 130% yields a MAR of $625.00.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   - "VAPR ELECTRODE 4.0ML" as identified in the itemized statement and labeled on the invoice as "VAPR S90 4.0MM W/INTEGR HDP *EA" with a cost per unit of $255.00;
   - "LUPINE BR ANCHOR W/DS ORTH" as identified in the itemized statement and labeled on the invoice as "LUPINE BR DS W/ORTHCRD" with a cost per unit of $334.00;
   - "5.5 HEALIX BR ANCHORW/ORTHOCORD" as identified in the itemized statement and labeled on the invoice as "5.5 HEALIX BR ANCHOR W/ORTHOCORD" with a cost per unit of $350.00;
   - "MAGELLAN PRP" as identified in the itemized statement and labeled on the invoice as "Magellan PRP" with a cost per unit of $1,200.00.

   The total net invoice amount (exclusive of rebates and discounts) is $2,139.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $213.90. The total recommended reimbursement amount for the implantable items is $2,352.90.

5. The total allowable reimbursement for the services in dispute is $10,073.21. This amount less the amount previously paid by the insurance carrier of $4,998.49 leaves an amount due to the requestor of $5,074.72. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,074.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,074.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.